inmate that you wanted a prophy and a -- well, strike that.

Are you familiar with the policy directives that stated at one time scaling/root planing, where now it currently just says scaling and root planing, is no longer on the policy. Are you familiar with that?

MR. DEAN: Object to form, but go ahead.

THE WITNESS: No. I don't remember or don't recall. No.

BY MS. GITTLEMAN:

Q. Okay. Do we agree that the process of scaling and the process of root planing are two separate processes -- processes?

A. Yeah.

Q. Can you now, and within the last five years, prescribe to an inmate as part of your treatment plan a root planing and scaling?

A. Well, I guess debridement would be the term we use. To debris, you know, all the calculus, the plaque.

Q. Okay. So --

A. That's what it is basically, yeah. Debridement.

Q. Okay. Debridement. So we're clear, you're familiar with the American Dental Association coding, as well as coding procedures in the MDOC. Correct? That there

are codes specifically used?

MR. DEAN: Object to form, but go ahead.

THE WITNESS: You mean on the computer for the treatment?

BY MS. GITTLEMAN:

Q. Yes.

A. Yes.

Q. Okay. And a prophylaxis has a specific code, versus a debridement has a different code. Right?

A. Right.

Q. Okay. And we agree that a prophylaxis is a separate and distinct procedure from a debridement. Correct?

A. Correct.

Q. And we agree that a debridement is a separate and distinct procedure from root planing and scaling. Correct?

A. Yes.

Q. And do we agree that a prophylaxis, or prophy -- a prophylaxis is also a term for prophy for short. Correct?

A. Yes. It's a prophy. Yeah.

Q. And we agree that a prophy is the removal plaque, calculus and stains from the tooth structures in the permanent and transitional dentition. Correct?

A. Yes.

Q. And do we agree then that a debridement is the gross removal of plaque and calculus that interfere with the ability of the dentist to perform a complete oral evaluation?

A. Yes.

Q. Do we agree that a debridement procedure does not accomplish the same treatment as a root planing and scaling?

A. Yes.

Q. And the reason is because a -- well, strike that.

We agree that a root planing and scaling is a procedure involving instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. Right?

A. Yes.

Q. And that root planing would talk about actually removal of bacteria, hardened calculus, necrotic tissue and smoothing out the root. Yes?

A. Yes. Smoothing the root surface.

Q. And that -- that process to the roots will remove bacteria so that bacteria is no longer eating away at the tissue?

A. Yeah.

Q. But a debridement does not involve root planing. Correct?

A. Correct.

Q. So my question then is, you indicated that you would prescribe a debridement to a patient earlier. Correct?

A. Would I? Yeah, I would.

Q. Okay. And do you prescribe a debridement for treatment of periodontal disease?

A. No. It's to remove the gross calculus.

Q. Okay.

A. Or tartar. Whatever you prefer.

Q. So do you prescribe as a treatment plan, root planing and scaling on an inmate patient?

A. Do I prescribe it?

Q. I mean either you do or you don't.

A. No. I mean I do the prophy, you know, to remove the main part and get the best you can is how I do it. Yeah. So it's a little limited.

Q. Well, are you limited because of the way you treat the patient or are you limited because of the MDOC policies and procedures?

A. Per the policy and procedure.

Q. Okay.

A. Right. I mean --

Q. I mean because you are the dentist?

A. I'm limited in everything I do. I'm limited to what I can and can't do, basically. Yeah.

Exhibit 1 - Minnich's Deposition

THE WITNESS: I would say, yes, but I do the best I can and estimate it.
BY MS. GITTLEMAN:
Q. At this point I'm just interested in the standard of care. Not your limitations.
A. Okay.
Q. And what are -- well, I guess I'll ask that question, then. As far as being in the MDOC, you're limited in your ability pursuant to the standard of care to diagnose periodontal disease. Correct?
A. Correct.
Q. And tell me why you are limited.
A. I base mine on like the, you know, the bitewings or the x-rays taken. I have no probing depths or, you know, no full-mouth prober -- or periodontal charting, I'm sorry, with the attachment levels and all that. No.
Q. Does the MDOC even provide a periodontal charting document that you can use?
A. I don't know if there's one on the electronic record or not, no. I'm not aware of it. If that's what you mean? No.
Q. Yeah, it is. And then even in the hard charts, from the documents I have reviewed, I've seen a dental history and I've seen charting of the cavities and what teeth are missing. That type of thing.

A. Right.
Q. But there's no periodontal chart per se hard written that you can actually use to chart pocketing.
A. No.
Q. I am correct? Yes?
A. As far as I know, yes.
Q. Okay.
A. Yeah.
Q. And is it true, then, that because of the MDOC policies and procedures of no probing, that your periodontal diagnosis may under diagnose the severity of the disease process in a patient?
MR. DEAN: I'm going to object to form and foundation, but go ahead.
THE WITNESS: Could it? Possibly.
BY MS. GITTLEMAN:
Q. Do we agree that in order to diagnose the progression of periodontal disease, you need to make a comparison of probing depths on one date to a subsequent probing depth results. Correct?
A. Yes.
Q. And that --
A. Along with x-rays.
Q. Along with x-rays. Well, the standard of care is the dentist uses x-ray, whether it be a full-mouth set or

bitewing and periapical, along with probing and charting those measurements, to diagnose periodontal disease. Correct?
A. Yes.
Q. Okay. But --
A. And mobility of the teeth, too.
Q. And what else?
A. And mobility of the teeth.
Q. Okay. You agree that when a tooth is mobile, that's advanced periodontal disease. Right?
A. No. It doesn't have to be advanced if it's like a class one, it would be a moderate. You know, moderate, not mild, but more of a moderate. If it were a three, then I would say you're in the advanced stages. Right.
Q. Okay. So you can have mobile teeth in moderate periodontal disease as well?
A. Correct.
Q. It's true that to diagnose the progression, the dentist, pursuant to the standard of care, needs a baseline which would be through the bite -- the x-rays and periodontal probing. Correct?
A. Yeah. Yes.
Q. Can a dentist using the standard of care properly diagnose the stage of periodontal disease of a patient if they only have their eyesight visually and a

panorex?
A. Properly diagnose? No. You could give a good estimate of it. It wouldn't be the exact diagnosis, but you could give a, you know what I mean, to the best of your ability looking at that.
Q. Okay. Does the standard of care permit -- well, strike that.
Does the standard of care bless a dentist only having visual and a panorex to diagnose periodontal disease?
A. No.
MR. DEAN: I'm going to object to form and foundation, but go ahead.
THE WITNESS: No.
BY MS. GITTLEMAN:
Q. It's true that if a -- well, strike that.
You had said earlier that you can do your best as a dentist to estimate the periodontal disease, whether it's gingivitis, early, moderate or advanced, you can do the best to estimate with just a panorex and visual. Correct?
A. Yeah. To the best of your ability, right. Right.
Q. But it's true that if those are the only treatments -- strike that.
It's true if those are the only tools

Exhibit 1 - Minnich's Deposition

used to diagnose the periodontal disease, being visual and panorex, then the disease, periodontal disease, would -- certainly could be under diagnosed or more serious than what is actually -- what the patient is actually suffering?

MR. DEAN: Objection to form and foundation, but go ahead.

THE WITNESS: Yes.

BY MS. GITTLEMAN:

Q. And without the adequate information for the dentist to use to diagnose periodontal disease, being probing and the proper x-rays, the disease, periodontal disease, could be more serious than the diagnosis by the dentist. Correct?

A. Could you -- I'm sorry. Could you -- she repeat that again?

MS. GITTLEMAN: Sure.

COURT REPORTER: Question: And without the adequate information for the dentist to use to diagnose periodontal disease --

MS. GITTLEMAN: I can do it again.

COURT REPORTER: Okay.

BY MS. GITTLEMAN:

Q. Where the dentist only has the visual and a panorex to diagnose periodontal disease, that information gathered

from a visual and a pano, is inadequate information to diagnose the stage of periodontal disease. Correct?

A. Yeah.

Q. And because of this inadequate information, being visual and a pano, the disease, the periodontal disease, could be worse or more serious than what is diagnosed because the dentist doesn't have the proper information to make that diagnosis. Correct?

A. Yes.

Q. So a person diagnosed with early periodontal disease, based on a visual and pano, might really have moderate periodontal disease because inadequate information was used to make that diagnosis?

A. Possible, yes.

Q. Okay. And if you have a patient who has early -- strike that.

If you have a patient improperly diagnosed with early periodontal disease, that can worsen over time to become moderate or advanced without treatment. Correct?

A. Over time, yes, it could.

Q. Okay. And if you have a patient -- if you have a patient with early periodontal disease who has no treatment for the periodontal disease for two years, that periodontal disease can worsen over time as well.

Correct?

A. It could, yes.

Q. And that worsening, meaning the loss of periodontal attachment and bone loss, will not regrow. Correct?

A. Correct.

Q. It's a permanent life-long condition worsening. Correct?

A. Yes. It's not coming back.

Q. What keeps a tooth in place?

A. You mean the bone? The periodontal ligament and the attachment? Is that what you mean?

Q. Yes. I mean it's basic, but I have to ask the question.

A. Oh. Okay. Yeah. Okay.

Q. So what keeps the tooth in place?

A. So if you don't have the bone level or the attachment level, then you have mobility. Then you could end up -- sometimes a tooth will fall out if it's advanced on its own or you have to take it out because you're more susceptible to gum disease. You know, it's like perio -- what's called -- some people call it here, pyorrhea or gum boil. An abscess.

Q. Well, it's funny you mention the word pyorrhea, because I thought pyorrhea was from like 1910 and my grandma had pyorrhea and she lost all her teeth. So I don't

know .

A. Yes. It's been around forever. That's what they called it. Yeah. Yeah.

Q. Okay. But we call today, in today's standard of care, in modern dentistry, it's periodontal disease. Correct?

A. Correct. Correct.

Q. And periodontal disease is treatable and preventable. Correct? With the proper treatment?

A. Yeah. Yeah. Right. Well, yeah, you need the help of the patient, too. Like don't smoke. Oral hygiene is good. Flossing, brushing. Yes.

Q. But even -- does smoking make you at more increased risk of suffering periodontal disease?

A. Yes. From what they put out, yes.

Q. But even a smoker, who is at a higher risk, if receiving the proper treatment for periodontal disease, can be maintained. Correct?

A. Possibly. But I would advise them to stop smoking, is what I would do.

Q. But is the standard of care of private practice -- the standard of care in private practice, with a smoker or a nonsmoker, no matter who it is, would require the dentist to either properly treat timely the periodontal disease or refer it. Correct?

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x-rays, exposes the inmate to a substantial risk of serious harm because periodontal disease either goes under diagnosed, undiagnosed or the treatment -- that would be my question. Should I repeat it? Did you understand my question?

A. No. Could you rephrase it or --

Q. Let me rephrase it. It's true that the failure to use periodontal probing and intraoral x-rays exposes an inmate patient to a substantial risk of serious harm because of the lack of inadequate information to diagnose the periodontal disease?

MR. DEAN: Objection to form and foundation, but go ahead.

THE WITNESS: Yes, it could.

BY MS. GITTLEMAN:

Q. Have you ever heard the term stable or unstable periodontitis?

A. I couldn't -- I couldn't hear you. I'm sorry. You faded out.

Q. Have you -- does standard of care have terminology defining stable versus unstable periodontitis?

A. Yeah. You could have a stable case, like where it's maintained and, you know, they are stabilized in that sense. Yes.

Q. Okay. And I'm going to ask you if I'm correct or not,

but within the standard of care, stable -- in private practice, stable -- a patient who suffers from periodontal disease can be stabilized with the proper treatment and recall and followup by the dentist. Correct?

A. Yes. Yes.

Q. If you only have a visual with your eyesight and a pano, panorex, can you determine if periodontitis is stable? That's all you have.

A. I would have to say no.

MR. DEAN: We're at another --

THE WITNESS: Can we take a break? A bathroom break?

MS. GITTLEMAN: Sure. Sure. Whenever you need a break, let me know. I'm happy to do it.

THE WITNESS: Yeah. About five minutes. Is that good?

MS. GITTLEMAN: Sure.

MR. DEAN: I'm going to take a little break myself.

(Recess taken at 1:10 p.m., resumed the deposition at 1:15 p.m.)

BY MS. GITTLEMAN:

Q. Doctor, are you -- are you familiar with a memorandum put out by Dr. Choi in 2018 regarding periodontal

disease and referencing a Dr. Jeff Johnson, DDS?

A. Jeff Johnson? No. No, I don't recall.

Q. Okay. Do you know Dr. Mark Cook?

A. I know of him. Yes.

Q. He's a dental -- he's a general dentist within the MDOC. Correct?

A. Correct. Yes.

Q. And how about a Dr. Carla Maxwell. Is she with the MDOC, too?

A. I know the name, but I don't know who she is.

Q. Okay. How does one get on the Dental Advisory Board? How does that happen? If you know?

A. I don't.

Q. And I only ask because you said you were on there at one point in time. How did you get on there?

A. Rebecca Goodman asked if I could take Dr. Ruprecht's place.

Q. Okay.

A. But it was Dr. Taylor at the time. He was a dental director. So that's how I ended up, but I think I only went to one or two meetings.

Q. Okay.

A. Two.

Q. Does someone like yourself, a general dentist within the MDOC, attend any Dental Advisory Board meetings?

A. Besides the members? Is that what you're asking?

Q. I mean I'm asking if someone like yourself?

A. No. No.

Q. And you don't know who Dr. Jeff Johnson is. Right?

A. No. I don't -- I've never heard of him as a dentist, no.

Q. Okay. Do you agree that a general dentist is unable to determine the progression rates of periodontal disease without proper x-rays and probing and charting?

A. Without? Is that -- I'm sorry. Without?

Q. Yes.

A. I think you need all the necessary tools to diagnose.

Q. Okay. So then you do agree that a dentist cannot and is unable to determine the progression of periodontal disease without proper x-rays and probing, charting and then of course preparing it. Right?

MR. DEAN: Objection. Form and foundation, but go ahead.

THE WITNESS: Yes. In my opinion, yes.

BY MS. GITTLEMAN:

Q. Okay. Are you of the opinion that periodontal disease is a slowly developing immune response condition?

A. I think it could -- it could be a multitude of different things. Yes. It could be fast. It could be slow. I mean it could be, you know, different forms in

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dentist one millimeter, two millimeters, three millimeters is far down on a tooth. Correct?
A. That's pretty small. To be honest with you, yeah, two or three millimeters is a very small increment.
Q. Okay. How would you stage two millimeters? Is that normal or abnormal?
A. Yeah, that's pretty much -- the actual normal -- and it's been a while -- I do believe it's within the two-millimeter range. And that's why when you were asking me about toothbrushes, yeah, they can go down below two milliliters -- two millimeters. I'm sorry -- not milliliters. Two millimeters.
Q. So early periodontal disease is when a pocket depth or attachment loss, according to the American Dental Association, is three to four millimeters.
Do you agree with the American Dental Association's classification?
MR. MERTENS: Objection. Form and foundation. Go ahead.
THE WITNESS: It sounds reasonable.
MS. GITTLEMAN: Okay.
BY MS. GITTLEMAN:
Q. So would there be -- strike that.
When you -- have you ever appointed a patient in the MDOC for a perio scale?

A. Have I ever recommended perio scale or have I ever treated perio scale?
Q. No. No.
A. Yes.
Q. Okay. You have you said. Yes?
A. Yes.
Q. And how do you -- how do you -- how did that get into the EDR during your treatment plan?
A. Say that again. How did it get into the --
Q. Yeah. How do you appoint a patient for perio scale in the treatment plan?
A. Yeah. So, you know, sitting here right now, I can't answer that. I would -- I said this before, I would just write it into the -- the record.
Q. Okay. So can we --
A. There may be a box. I don't know.
Q. Does the box just say prophy on it?
A. I don't know. I really don't know. There may be a box -- in this new program that we have there are a lot of boxes for this and that. And my way to not worry about that computer issue is to write things verbatim what I want to say.
Q. And this new program you're referring to, is this COMS? C-O-M-S?
A. Yes, ma'am.

Q. Okay. Have you had the opportunity to use the COMS for routine care?
A. Oh, yes.
Q. Are you doing routine care during COVID?
A. No. The COMS, the COMS we were utilizing before COVID.
Q. Oh, you were. How long before COVID?
A. I can't actually answer it, but it seems to me that we were two or three -- I mean we're using it now, but it seems to me that COVID became acute in February, March, and it seems to me we were using COMS way before then. Like the fall of last year.
Q. Okay.
MR. MERTENS: Ms. Gittleman, we went back on at 1:05. It's 2:20. At your next available moment, can we break for a hard five? I note that Dr. Potts is eating on something. I don't know how clear --
THE WITNESS: I apologize. I'm eating peanuts. I'm eating almonds.
MS. GITTLEMAN: It doesn't bother me one bit.
BY MS. GITTLEMAN:
Q. So going back then to our questioning a few minutes ago, which was prophy versus perio scale, I want to summarize and make sure I understand.

The prophy was supragingival removal.
The perio scale is supragingival removal, and maybe down two millimeters subgingival. That's it. Correct?
A. That is not quite -- I don't think anybody else would use those terms, but that's basically the idea. All I'm saying is that if you scale -- if you're doing a prophy on someone and you see hard objects, you remove it. If you see it, and you can reasonably reach it right below the gingival surface, yes, you remove it for the patient.
Q. Would you consider a perio scale equal to root planing and scaling?
A. A perio? Oh, my goodness. Wow. It looks like we're word -- we're word splitting today. Root planing and scaling is different than a perio scale, but I don't split hairs that fine.
Q. Well, let me ask it this way. If you're treating a patient in the MDOC as a general dentist and you see the terms prophy scale completed, do you know if he had a root planing and scaling or he had a perio scale, which is a different procedure?
A. If they said -- if the term was prophy scale completed, I take it verbatim that a prophy and a scaling was completed. If it said prophy scale, root planing, I take it at face value.

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